CERIDIAN freedom

COBRA OPEN ENROLLMENT SELECTION AGREEMENT

Effective: January 1, 2007

Employer: COMMONWEALTH OF KENTUCKY **Ceridian Account # 610600439**

COBRA PARTICIPANT INFORMATION

Participant's Name – Last | First | MI

Social Security # | Date of Birth (M M D D Y Y Y Y) | Daytime Telephone # (include Area Code)

Mailing Address: Street (include apt. #) or P.O.Box

City | State | Zip Code (+ 4)

Check this box for mailing address change ☐ If you are the dependent of a former employee, enter that employee's Social Security #

PLAN YEAR 2007: You must enter all Coverage Type(s) for changes, deletions and/or additions below.

* Please refer to the enclosed "Monthly COBRA Rate Sheet" for the applicable carrier code, option code and family status code you wish to change, add or delete.

Change	Delete	Add	Coverage Type	Carrier Code*	Option Code*	Family Status*
☐	☐	☐	Medical			

Selected Coverage change only apply to coverage offered by your former employer's group health plan as indicated in the Open Enrollment cover letter. Selected changes for option not available to you will not be processed.

DEPENDENT CHANGES

Change	Delete	Add	Name Last	Name First	Relationship	SS#	Date of Birth	Coverage Type** Medical
☐	☐	☐						☐
☐	☐	☐						☐
☐	☐	☐						☐
☐	☐	☐						☐

** Dependent changes only apply to individuals that meet the definition of a dependent as defined by your former employer's group health plan.

YOUR CERTIFICATION

I authorize the benefit coverage choices I have made on this form and understand that these choices will remain in effect for the 2007 plan year, or until the expiration of COBRA continuation coverage, whichever comes first. I further certify that all information is complete and accurate to the best of my knowledge. If you and/or your Qualified Beneficiaries have not yet made an election of COBRA Continuation Coverage, we will, upon receipt of your *COBRA Open Enrollment Selection Agreement*, process your election for COBRA Continuation Coverage to include all the benefits you were offered in your Important Notice (including FSA [Flexible Spending Account], if you have one). Open enrollment changes will be effective January 1, 2007.

Your Signature _____ Date ___/___/____

Return form to: Ceridian COBRA Continuation Services
P.O. Box 534123
St. Petersburg, Florida 33747-4123
877/504-4052 • Fax: 727/865-3648